Department of Human Resources
Division of Health Care Financing and Policy
Meeting for Public Comment on Review
Of Nevada Medicaid Services Manual and
The State Plan for Medicaid Services
November 15, 2005

Minutes

Attendees

In Carson City, NV
Mary Wherry, Deputy Administrator, for
Charles Duarte, Administrator
John Liveratti, Chief, DHCFP, Compliance Unit
Darrell Faircloth, DAG
Others in attendance shown on attached lists.

In Las Vegas, NV
Marcie French, AA II, DHCFP

The meeting was called to order by John Liveratti, Chief of Compliance at 9:00 a.m. in room 3138 of the Legislative Counsel Bureau in Carson City, Nevada. The meeting was aired by video conference to Las Vegas simultaneously. Those in attendance are on the attached lists from both locations.

1. Discussion and Proposed Adoption of Amendments to MSM Chapter 400-Mental Health and Alcohol/Substance Abuse Services

Coleen Lawrence, Chief of Program Services and Kathryn Cordell, Social Services Program Specialist III discussed the changes to MSM Chapter 400.

She stated that of the amendments that will be addressed, the largest one is the Alcohol and Substance Abuse of the original MSM Chapter 2900 was inadvertently left out with the revisions. They will add back in those policies in their original content as they are now in the chapter.

400 Introduction- added to Page 1, Paragraph 1, Line 1, added language to clarify that Nevada Medicaid reimburses for community based and inpatient mental health services to both children and adults under a combination of mental health rehabilitation, medical/clinical, and institutional authority.

Page 1, Paragraph 1, Line 7, changed sentence to read, “The services are to be provided in the least restrictive, most normative setting possible and may be delivered in a medical professional clinic/office, within a community environment, while in transit and/or in the recipient’s home.

Also corrected in the chapter were some typographical errors that are being clarified as to the proper placement of “in” and “the” where appropriate.

402.26 Medical Supervision, Page 6, Paragraph 4, Line 5, changed to read, “Medical supervision includes the on-going evaluation and monitoring of the quality and effectiveness of the services provided and may be provided through on and offsite means of communication.”

402.31 Psychological Testing, Page 7, Paragraph 1, Line 1, removed the word psychopathology and replaced it with diagnosis(ses).

402.33 Severe Emotional Disturbance (SED) and 402.34 Serious Mental Illness, deleted the IV behind the DSM language DSM (-IV) Axis I diagnostic category and made it consistent throughout the chapter.

402.37 Utilization Management Team, clarified the last sentence to say, "…and all outpatient mental health services and mental health rehabilitation services which exceed service limits specified in "the Medicaid Services Manual, Appendix B".

403.1a, Page 1, Paragraph 3, Line 3, regarding outpatient services, clarified DSM Axis I, instead of just being DSM.

403.1c, Page 1, added "and".

403.1, Page 1, Paragraph 4, Line 2 deleted: services that are delivered by Medical Supervisors, Qualified Mental health Professionals, Qualified Mental health Associates, Qualified Behavioral Aides, Family Supporters and Peer Supporters for all outpatient behavioral health services ad rehabilitative services covered in this chapter and replaced:

Behavioral Health Community Networks (BHCN) can be reimbursed for all services covered in this chapter and may make payment directly to the qualified provider of each service.

403.1(2) These providers are directly reimbursed for the professional services they deliver to Medicaid-eligible recipients in accordance with their scope of practice, state licensure requirements and expertise.

403.1(3), Page 1, Paragraph 6, Line 5, deleted, or and replaced: 403.1(3): Individual Mental Health Rehabilitative Providers who meet the provider qualifications for the specific service. The mental health rehabilitative provider must arrange for clinical supervision through a contractual agreement with a BHCN, if they cannot provide this requirement independently. These providers may directly bill Nevada Medicaid or may contract with a BHCN, or

403.2(2) added: A BHCN that is JCAHO, CARF, or COA accredited may substitute a copy of the documented quality assurance processes and plan required for the certification in lieu of the requirements of 403.2(2)(f).

This prevents providers from doing two quality assurance plans.

403.3(5), Page 4, Paragraph 4, the Qualified Mental Health Associates (QMHA) definition, added new paragraph: c. "Has a FBI background check in accordance to the provider qualifications of a Qualified Behavioral Aide (QBA)."

403.3(6) (d)(2) Reimbursement for interns is based upon the rate of a Qualified Mental Health Professional (QMHP) which includes the clinical and direct supervision of services by a licensed supervisor.

403.4 Outpatient Mental Health Services-deleted, "Traditional outpatient mental health services are available for reimbursement under the clinical services of the Nevada Medicaid State Plan authority."

Page 5, Paragraph 3, line 1 deleted QMHA and replaced:

403.4(4)(e) Crisis Intervention- added language to read, "These services may be mobile and may be provided in a variety of settings, including, but not limited to, psychiatric emergency departments, homes, hospital emergency rooms, schools, child protective custody and homeless shelters.

403.6(1) Family Supporter- added "Foster Child" to read, "A qualified individual who has had a family member or Foster Child with a diagnosed mental health disorder…"

403.6(3)(c) added clarifying language that the QBAs must submit to the designated BHCN or contacted Treatment Home Provider, a completed FBI criminal background check to ensure no convictions of applicable offenses has been incurred. Documentation of the request, and applicable

results, must be maintained by the BHCN or contracted Treatment Home Provider and made available to DHCFP, upon request.

403.6(3)(d) added terminology at the end of the sentence to read: Individuals who have been convicted of any of the following felonies or misdemeanors under federal or state law for which DHCFP has determined to be inconsistent with the best interests of recipients are excluded from eligibility for qualification as a provider of services covered in this chapter.

403.7 Rehabilitative Mental Health Services-deleted any language that said "licensed QMHP" as all QMHPs are licensed.

403.7(8) d. added: c. Basic skills training 2 hours per day: Providers must provide a certain amount of basic skills training for the core service and by adding this 2 hours per day provision, they are allowed to bill for additional basic skills training that exceeds that amount.

Appendix A-added to the bottom of the grid, "Prior authorization may be requested from the QIO-like vendor for additional assessment and therapy services for Level Three and above.

Add the Alcohol/Substance Abuse chapter section back into this chapter as it is currently in Chapter 2900.

Overall this chapter, per the MTL, is a combined effort to obsolete MSM Chapter 2900, Mental Health Rehab Treatment Services, and MSM Chapter 3400 Residential Treatment Centers. All these chapters will be combined into this MSM Chapter 400, Mental Health and Alcohol/Substance Abuse Services.

Mr. Liveratti asked for public comment on this chapter.

Mr. Tom Waite, CEO and President of the Girl's and Boy's Town of Nevada, President of the Nevada Youth Care Providers Group had a concern regarding the permanency and placement of youths. As the youth improves in treatment, while in treatment homes, there's a concern that they would be moved to another program/facility as the treatment succeeds. This seems to go against the eventual permanency that is sought for the youths that are cared for. He would like to have this discussed more in the chapter.

Ms. Lawrence asked Mr. Waite if he is looking for strengthening language that would say that the treatment should be consistent with a permanency plan.

Mr. Waite agreed that something along those lines to emphasize the focus of permanency.

Ms. Wherry told Mr. Waite that there would need to be an investigation as to what is Medicaid regulatory language and relevant to behavioral health care services that we pay for vs. what are child custody issues within the domain of DCFS through the counties. DHCFP can look at that language although it would only be in the context of the Medicaid regulations for reimbursement.

Ms. Wherry continued that she thinks the chapter is very clear, that we have a goal for children to be placed in a stable environment with treatment coming to them, but she's not certain it's DHCFP's role as a Medicaid payer to determine what permanency is, where it is, and how those services are provided. We will look at it, but may not be able to strengthen language if it falls into the regulations of other agencies.

Karen Taycher, Executive Director, Nevada Parents Encouraging Parents, had a written log of issues passed out in the Carson City, as well as the Las Vegas meeting. It was titled, "Public Hearing 11/15/05, Issues brought forward by Nevada PEP".

Ms.Taycher spoke for the organization she represents by saying she believes the redesign will benefit families and Nevada PEP thanks everyone involved in making the redesign a reality.

Ms. Taycher addressed Section 403 page 10 of MSM Chapter 400. The selection of the family supporter sounds as though a QMHP may select the worker they want working with the family rather than selecting the services or organization providing services. In the system of care it is clear that families should be able to choose the services they want for their family.

Ms. Lawrence said that in Appendix A, under the Emergency Shelter section, there was confusion over a typo. It had originally had CASII Level 3, but she was told to keep consistent with the Treatment Home providers at CASII Level 4.

Ms. Lawrence asked Ms.Taycher if she was referring to 403.6(1), where it states, "the selection of the family supporter is based upon… be approved by a qualified mental health professional". The statement is that a QMHP must sign off that that person is an able-bodied person to be able to perform the services needed of a family supporter, so they aren't choosing the provider, just signing off that they are a legitimate provider of the service.

Ms Taycher asked if they could clarify that better in the chapter, to show that the family has the ability to choose the provider. Mr. Liveratti asked Ms. Taycher if she had any written language samples she could give to help clarify this and she said she could put something together during the current hearing and get back to him before the end of the hearing.

Ms. Lawrence informed Mr. Liveratti that in MSM Chapter 100, for consideration, the recipient always has the right to choose their provider, so this actually falls under a larger set of regulations regarding freedom of choice.

Mr. Liveratti asked if there were any more questions or comments.

Ms. Joy Salmon, CCDFS, was unclear on issue of treatment plan, she knows the Service Coordination Plan definition and language was removed and wants to know if by the current language to have a treatment plan done by each provider or is there an over-arching treatment plan.

Ms. Cordell responded that the treatment plan needs to be done by the authorizing licensed clinical practitioner, or the licensed QMHP. All services have to be under that umbrella. Each provider has asked that we include that language so that they can write their own treatment plan for the provision of those services. In summary, there is an overall treatment plan and separate treatment plans for each provider.

Ms. Salmon stated that there are still several references to the Service Coordination Plan that may need to be addressed. In addition, she clarified that she thinks they are adding back in references to alcohol and substance abuse that were in the other chapter, but currently aren't any references to it in this chapter. Mr. Liveratti confirmed this.

Also confusing for Ms. Salmon is the criteria for admission for Residential Treatment Centers (RTC) and Acute Psychiatric Facilities.

Ms. Lawrence stated that all the policies from MSM Chapter 3400 will be in this chapter, but due to time constraints, they were only focusing on the Mental Health Rehab and Outpatient Services. They have not modified the policies from MSM Chapter 3400 or had any type of comments on them. The next step is to look at inpatient and RTC admissions and all the utilization management criteria so they will be consistent and remain as is in MSM Chapter 3400. They will have Substance Abuse, Alcohol Treatment, Inpatient, Psychiatric, RTC's, Outpatient and Mental Health Rehab in the final MSM Chapter 400.

Mary Wherry clarified that what she understood all this to mean was whatever language that was in the existing MSM Chapter 400, which is probably dated back to September of 2003, has not been changed. Thus those regulations have not changed since September 2003, but going forward, for future public hearings we may be looking at those types of distinctions.

Ms. Salmon had another question regarding the Intern sections-the Psychological Intern isn't included, and she would ask for consideration to include them in the two sections of MSM Chapter 400.

Ms. Lawrence stated that at this time, they were able to do the research on the Licensed Clinical Social Worker (LCSW) and the Marriage/Family Therapist (MFT). The Psychological Intern is slated as the next step for research for addition to this section. It hasn't been placed in the chapter yet due to not having researched it yet.

Ms. Salmon stated that there are at least two references in the chapter that speak of children in DCFS custody because of integration now, it should state "in custody of a public agency" instead in terms of being consistent with the counties having child welfare.

Mr. Liveratti said they would correct that in the grammar clean up section.

Ms. Salmon had a question regarding Appendix A, on page 3, it speaks to secure RTC's. She said that in Nevada there are no non-secure RTC's, and although there could be a non-secure RTC, whether that would fall under Level 6, or be deferred to Level 5? Due to the current AB 369 requirement, this makes it critical issue for them.

Ms. Lawrence stated that with the RTC requirements, they have called them "secured" and that is the current as well as past policy, so they have not changed it. If they need to look at that with the next chapter hearing on the RTC's, they'll look at that at that time.

Ms. Wherry asked Ms. Salmon if in the existing policy, not the one being discussed today, but the current policy, in MSM Chapter 3400, where the levels are discussed up to Level 5, one of them is not a medical model and thus not necessarily secured, is this what Ms. Salmon is referencing?

Ms. Salmon stated that even in the medical model RTC, but non-secure. She knows there aren't any in Nevada currently. Ms. Wherry stated that would be an oxymoron to DHCFP as all RTC's are considered locked and secured facilities by DHCFP definition (provider type 63). Anything less that than that is non-secured and not a medical model would be a provider type 61.

Ms. Salmon asked in terms of the licensing reference for Treatment Homes for children and adolescents, under NRS 424, is this the Foster Group Home licensing? Is this the only type of licensing that would apply to these types of homes?

Ms. Lawrence replied that the treatment home providers are under NRS 424, Foster Care, and that is up to a different agency other than DHCFP, but we are using that as a reference.

Mr. Liveratti asked for questions or comments.

Patricia Marrifield, Deputy Administrator, DCFS, thanked DHCFP for their inclusionary process that has taken many months but resulted in a much better set of regulations. She would like to follow up on NRS 424. She asked DHCFP to double check as NRS 424 only covers Treatment Home Facilities up to 16 residents. Some are provider types under Rehab Option Services-provider type 61-that are larger than 16 and require under NRS to be licensed under the Health Division. She asked that DHCFP double check their references and make sure the Health Division NRS is also referenced for the larger facilities.

Ms. Marrifield has some wording changes she would like to relate. They are: 402.14, Discharge Summary, the last sentence currently states, "the Discharge Summary is a component of the Discharge Plan." The way Discharge Plan is defined, it's a Treatment Plan that happens prior to Discharge, as summary happens post-discharge; she recommends this sentence be deleted as it's inconsistent with the two definitions.

Ms. Marrifield spoke of 403.1, she believes the intent is that "Nevada Medicaid reimburses for out-patient mental health **and/or** Mental health rehabilitative services…" the current sentence only says, "and" is this correct, because not all the models provide both.

Ms. Lawrence yes, it can read "and/or" in the first sentence.

Ms. Marrifield had one more correction for 403.3(1), the definition of Case Manager. The second to last line that says, "…their to provider choice" is a typo and should actually read, "their right to provider choice". Ms. Lawrence confirms this is indeed what the sentence should read.

Ms. Marrifield questioned 403.6 (3)-the definition of a Qualified Behavioral Aide (QBA). When she reads through the service types, she sees that QBAs are providers for other service delivery model types that were discussed in 403.3 (1). Other than a BHCN or treatment home provider, which would include a Rehab provider because you have a Rehab provider as a separate provider type and a QBA provides basic skills training which is a rehab provider-type service. She suggests that on the fourth line of the QBA definition, that we add "or rehab provider".

Ms. Lawrence clarified for Mr. Liveratti that the sentence would read, "a QBA may only provide services as a peer supporter, family supporter, treatment home provider, and/or a rehab basic skills provider…under direct contract with a BHCN, treatment home provider, or rehab provider" because they can be separate providers as the chapter is written.

Ms. Lawrence agreed and when original amendments were written, this was clarified throughout the document.

Ms. Marrifield also suggested that the first sentence of 403.6 (3)c also be changed to include the rehab providers. The sentence may read, "Have submitted to the designated BHCN, treatment home provider, or rehab provider…" depending on whom they're employed by.

Ms. Marrifield brought up the RTC section. This is the section where Joy Salmon was talking about public child welfare agencies, which Ms. Marrifield recommends they make the change in the RTC section as most children in foster care are not in custody of the State of Nevada, but in the custody of one of the two major counties.

She also asked that on the section 403.10(A) (6) pages 19 & 26, Therapeutic Home Passes, to make it consistent, where the paragraph discusses, "…a total of 20 days per recipient per calendar year"…then on 403.10(A)(6)d, it states, "…exceeding a total of 12 days per calendar year", she recommends changing the 12 days to 20 for consistency.

Mr. Liveratti asked Ms. Taycher if she had come up with some language change suggestions. She is suggesting the following change to page 10 of 403.6, item 1: "The selection of the Family Supporter is based on the best treatment interest of the recipient, family choice, and must be approved by a Qualified Mental Health Professional on the Treatment and/or Service Coordination Plan."

Mr. Liveratti asked if there were any questions or comments from either Carson City or Las Vegas.

Jennifer Bevacqua, of Olive Crest, the Nevada Youth Care Providers, had a comment is on 403(B), page 11, the definition of Qualified Behavioral Aid (QBA). The last sentence that speaks of being under the "direct supervision of a Qualified Mental Health Professional", in that definition, it states that a QMHA could also do direct supervision. Her recommendation would be changed to include a QMHA to provide direct supervision of a QBA.

Ms. Lawrence stated that she didn't think this was something they need to take into consideration because the difference and impact if changed is unknown because one is a licensed professional, and one is a non-licensed professional.

Mr. Liveratti said they'll do a future amendment on this after this one is closed.

Ms. Bevacqua asked if the current treatment home providers-where the treatment providers would be QBA's, and do not have QMHP's on staff-do they need a QMHP to be a treatment home provider, because that is currently not the case.

Ms. Cordell responded what that refers to is the authorization of those services under the original treatment plan that recommends the treatment home services, so that would be the licensed individual that has determined with input from the recipient and the treatment team, or inter-disciplinary team that the services are authorized, so that umbrella, QMHP, would be the one that you would look to for that supervision of those services.

Ms. Bevacqua is trying to understand in terms of how it relates to their current programs. A stand-alone, private provider agency can still have their treatment homes they oversee without having a QMHP on their own staff; direct supervision is coming from the referral process. Ms. Cordell stated that this is correct-in the referral process the Utilization Management (UM) criteria and the team that is recommending those out-of-home placement has to be a licensed professional that has determined the medical necessity of those services, so they do not have to be part of the facility staff.

Ms. Wherry said she thinks this ties back to an earlier question regarding Ms. Salmon's clarification of the treatment plan and that there would be a qualified home professional who has a treatment plan and we would expect to see on their treatment plan the child's placement, whether that's a provider type 61 or 82. Then the private provider agency will have their own treatment plan, but DHCFP would expect that the QMHP is making that referral and overseeing that individual. That is the medical necessity component that Ms. Cordell was referring to as a Federal requirement.

Ms. Bevacqua is still trying to see how it fits into their program. Mr. Liveratti said that Ms. Lawrence or Ms. Cordell can call her personally and go over it with her.

Ms. Wherry clarified that it may be in the past they haven't had that type of relationship, that this is one of the reason for these public workshops and public hearings, because we are trying to clean up and assure compliance with all of the regulations. The reality is we are opening up the market, but have to have the determination of medical necessity by a QMHP. If we currently have children that have no current treatment plan by a QMHP, then they are going to need to begin collaborating with somebody who is going to be giving the referrals and doing the oversight.

Ms. Bevacqua brought up section 403, pages 13 and 15-the definition of Basic Skills Training and Psychosocial Rehabilitation. Do they both have the same requirements regarding supervision for those services?

Ms. Lawrence clarified that Basic Skills Training allows for a QBA or a treatment home provider to provide services; the need to have the direct supervision. Under a QMHP and QMHA, they *are* the direct supervision with their licensure. They were trying to cover the QBA's responsibilities under the Basic Skills Training; this is why she doesn't see it in both places. The QBA cannot do psychosocial rehab.

Ms. Bevacqua reiterated that a QMHA can supervise themselves under psychosocial rehab and Ms. Lawrence said that is correct.

Ms. Bevacqua had another question in regarding children that are currently in-care, whether they are Level 2, or Level 3 at this time, is there a transition plan come January 1, 2006? What is it going to be when that system is no longer in place? Is there going to be an interim time for changeover to new system?

Ms. Wherry answered that her understanding is that DCFS and the counties have been identifying those children they believe might be affected. DHCFP's intent is to hold harmless the child and provider as we go through the transition process. She is under the impression that for the most part the majority of the children have been identified and they are not going to go through a big transition.

There were less than ten children statewide who would need to be grandfathered and have a more specific plan.

Ms. Merrifield stated that at this point they have identified all the children currently in Level 1 group care who don't meet admission criteria for the new treatment homes. There are about 12 statewide at this point. DCFS went to the Steering Committee and recommended the hold harmless and grandfathering and they just need to work with DHCFP on the details of making sure the paperwork is correct on January 1, 2006. They are meeting this Thursday afternoon with all of the Level 3 treatment home providers to look at those children to make sure they write treatment plans that meet those children's needs, because they look like they are going to qualify for the most part and need services in addition to the treatment homes.

Ms. Wherry recommends to Ms. Bevacqua, and the association that she is partnering with, that if they believe they may have children that have not been a part of the identification that they follow through with Ms. Merrifield in the south and Les (no last name mentioned) in the north.

Ms. Lawrence clarified that it was presented at the Steering Committee that there are a handful of children and that authorization would be extended. They do not meet the admission criteria for coming into a treatment home provider, however they will receive the core services of a treatment home provider so that they will be receiving all of the services and that they are meeting the continuing stay criteria. So it's actually the UM criteria that we are grandfathering in for these children and not the actual services.

Ms. Bevacqua stated that what providers are concerned about is having these children switch over on January 1, 2006 to a basic treatment level when some may have a need for additional services. What it's going to look like as they are trying to learn the new system and figure out what services they need under the new service types to maintain the children in their placements. Having that overload on a system at one time is their concern. One suggestion they had was that since there are TPA's for the current level system to honor those until they are up and then move the children on a case-by-case basis over to the new system.

Ms. Wherry responded that her understanding is that a number of the TPA's who were actually extended beyond January to make sure they didn't have a lapse. DHCFP brought up other provider types where a new program had been started at a point in time, for example, January 1, 2006. DHCFP is well aware that there is a transition period, but really need the providers to attend the provider trainings that will be forthcoming through November and December 2005, so they are all well aware of what the expectations are and how best to transition the children and the extension of services.

Ms. Sandy Arguello, Director of Koinonia Foster Homes, and a member of NYCP. The question she has today came out of NYCP. What kind of assurances do providers have to come back to the table as to adjust either the rate methodology or policies as written in MSM Chapter 400? If they detect inadvertent gliches, what would that time frame be?

Mr. Liveratti explained that the Rates issues will be discussed in the next section of this hearing.

Ms. Arguello continuted with regards to the policies. They know they can see things that they can anticipate will be gliches, how will MSM Chapter 400 be addressed, will they have to wait every two years?

Mr. Liveratti explained that the normal process for change to the chapters is each chapter in the Medicaid Services Manual is a living document and thus can be rewritten part of or in whole at any time. It would be comments that the Program Specialist at the Division received that make them say there needs to be change. The more interaction the providers have with DHCFP staff, at all levels, then that will lead them to bring items that need to be changed. If the providers don't communicate with staff, then there will be no change. If we think there needs to be discussion or change, workshops will be held at any time. DHCFP likes to hold public workshops first, flushing out all the

details, and then we put it in writing and then come to public hearing for the approval process. As such, the MSM Manuals are always up for change, but will not change without a public hearing.

Ms. Wherry made the point that if you look at agenda item #7, for example, Chapter 3500 is at almost every public hearing, but we have to give public notice, and file by the timelines set by legislature and the NRS, so it's very important that people work timely for change as it takes a minimum of several months to get change effected through the public process.

Ms. Arguello asked if a BHCN is obligated to provide all the BHCN's services outlined in the chapter, or is a BHCN obligated to provide what services its current staff is qualified to provide. In the document in one place it appears they have to provide all the services, but in another it says only to provide what you can actually provide. She didn't have the section number for reference. Because of this some providers are deciding whether to create BHCN's or contract with other BHCN's.

Ms. Wherry guided her to the definition section of the BHCN, where it's stated that the BHCN provides outpatient mental health services and may provide rehabilitative mental health services, so it's not being stipulated that they have to provide both.

Ms. Arguello clarified that there could be a number of small BHCN's who are providing what they actually are currently providing, but they have to be a BHCN to continue to do the work currently being done.

Ms. Wherry said yes, but the language that is used in the Behavioral Health Community Network is a concept that they're trying to get the provider community to embrace. In order to provide continuity of care for children and adults, there needs to be communication and a networking of providers to be sure the needs of the children and adults are being met. That is the intent with using the language of the BHCN, but it all comes back to having a qualified mental health professional, who has the treatment plan and is making the appropriate referrals and overseeing that the care is inclusive and comprehensive and client-centered.

Ms. Lawrence stated that under section 403.1, Service Delivery Models, there are four bullets that talk about what a BHCN must provide and the actual wording is, "BHCN's are public or private entities that provides *or contracts with* an entity that provides". Mental Health Services is not one of them; they are not required to abide by these four issues.

Ms. Arguello asked for clarification as to why Nevada is not following the lead of other states that are reimbursing MFT's and LCSW's outside of the BHCN model.

Ms. Lawrence stated that this initiative to have the Behavioral Health Community Networks has been in process since 2002. DHCFP has been working with our Legislative body since then to have BHCN's. At the time the decision was made to go with the BHCN's to create better access, to improve access, it was thought that having a network model was the most effective way of watching utilization management for those services.

Ms. Wherry would like to amend Ms. Lawrence's comment to indicate that we have had no true data to measure and evaluate the costs associated with who has actually been providing care to the children, primarily. The State agencies have each had their own systems of collecting information and we don't know what the costs are. One of the things that we'll be evaluating as the program moves forward is: who are the types of providers who are providing services, what are the clinical outcomes of the recipients and whether or not we have pent-up demand problems like we currently have. If access is an issue because people are having problems with networking, then we'll be looking at whether an expansion of that is necessary. Without historical data, it's impossible to forecast or make predictions, so what we did was look at the number of licensed psychologists in the state and how many were active Medicaid providers. By "active" we have a certain dollar amount that we use to judge if active or someone who was a Medicaid provider for a one-time event. When we take the same ratio and apply it to MFT's and Social Workers, it becomes larger, along with the potential costs associated with that. One of the problems DHCFP contends with as an agency is there are issues of

fraud and abuse, and DHCFP can only monitor so many individual providers. Those are the other things we need to take into consideration with regard to how wide we'll open up the market.

Ms. Wherry reiterated that MSM Chapter 100 is the foundation of the Medicaid program; it is the responsibility of all providers to be familiar and follow the regulations in MSM Chapter 100 because that's where the Federal requirements are discussed for all Medicaid providers for all Medicaid recipients. The examples would be that we have to assure comparability, what one recipient gets, all recipients can have access to; the freedom of choice rules and requirements for recipients; and one of the things that we have to guarantee with Federal government, is that we have sufficient access to Medicaid benefits. One of the things that stimulated this process of redesigning our Behavioral Health Program, is we have significant waiting lists throughout the State for children accessing Mental Health Services. If access continues to be a problem, then we'll do what needs to be done to evaluate if there is something we can do to fix it, and that usually ends up being an administrative, executive, and then Legislative decision making process when it comes down to the funding.

Ms. Merrifield spoke of section 402.11, the definition of Direct Supervision, states that direct supervision is provided by QMHP or QMHA. This indicates that direct supervision –not referral for services-but direct supervision of the practice-can be provided by QMHA's for QBA's.

Then on page 11, 403.6(3), the last sentence of the introduction states, "which are under the direct supervision of a QMHP". It doesn't say it's the referral, because the introduction clearly says all referrals must be by a licensed practitioner of the healing arts. Ms. Merrifield sees this as inconsistent and suggests the intent is as written in the definition of Direct Supervision, which is that QBA's can be supervised by QMHA's.

Ms. Lawrence stated that they are actually looking at that and they are going to make the document consistent, so they can change in the definition of QBA to add, "or QMHA" at the end of paragraph 3. The sentence would read, "A QBA must have the documented competencies to assist in the provision of individual and group rehabilitative services which are under the direct supervision of a Qualified Mental Health Professional *or Qualified Mental Health Associate".*

Mr. Tom Waite went back to earlier discussion on Treatment Plan. He wanted clarification regarding the "over-arching" treatment plan referred to and the treatment plan the provider treatment home might have for a youth in their care.

Ms. Lawrence explained that the overall statement was because DHCFP is trying not to be as directive as to the type of treatment plans out there because, in reality, there are treatment plans, service coordination plans, plan of care, etc. The services are an overall treatment plan that is being referred by the licensed mental health professional. They realize that individual providers also will keep a "plan", and so they are trying to stay away from what each and every "plan" item is called; they want to make sure there is coordination. They can look into it further, which is why one of the definitions was eliminated, because it was getting too confusing between all the different types of plans in the nomenclature that is utilized.

Ms. Lawrence asked Mr. Waite what type of clarification he would like to see in the document.

Mr. Waite stated that he thinks the concern from the provider's standpoint is that whoever is making the referrals for services, the providers have a variety of treatment philosophies that may be in place to provide treatment. The treatment home or the provider agencies, want to ensure that their programs are not being driven by the referral source to provide the treatment they believe the child needs, because they receive the referral.

Ms. Lawrence said that this becomes a lot larger than what we are calling a plan of care for the recipient. The issue becomes a communication of the provider that provides a service, and has documentation as to how that service is being effective or not. The provider will not provide a service without the communication with the custodial parent because (if the recipient is a child) it's a communication plan. Ms. Lawrence isn't sure how DHCFP can word in the policy, with these plans,

that the provider and the recipient-or the recipient's custodial parent-must work together to ensure those providers and the services are being delivered-that which are most appropriate for the child. Her hope is that in these over-arching utilization management policies that we have, that the services are agreed upon prior to and that it is best for the child.

Ms. Wherry told Mr. Waite that she thinks as we go through the transition, it's going to be incredibly important over the next three or four months or more, instead of blaming the utilization management process that we work collectively over time to determine what the flaws might be, as every time you begin a new program there are always challenges associated with the implementation of that program. It's going to come down to the documentation that is provided for the utilization management vendor as to whether or not it's adequate to support ongoing justification of the continued stay. Ms. Wherry thinks that's where the provider training is going to be very critical for the participation of Mr. Waite and his association, in that process. DHCFP's goal is to have open dialogue and work with the UM vendor to iron out some of the expectations.

Mr. Waite said that he looks forward to the training and ongoing communication that will come with it.

Ms. Wherry informed him that this is a two-way process, that the providers will need to pick up their phone and call DHCFP as well if they feel they're not being listened to or things aren't manifesting themselves the way the providers thought they were supposed to.

Vickie Kinnekan from Mohave in Las Vegas had CPT code clarification questions.

Ms. Lawrence explained to Ms. Kinnekan that it's always been DHCFP's policy that we don't tell providers what CPT codes are appropriate to utilize. The provider must use their best clinical judgement and billing practices to know which one to utilize. DHCFP offers the provider the Billing Manual to use as a guideline that is on the Internet. The Billing Manual shows which codes DHCFP believes are appropriate for services. This manual is actually the CPT book that is put out in part. Ms. Lawrence offered training to help with interpreting the billing codes, but is not able to tell her which codes are appropriate.

Ms. Kinnekan stated that some of the services they have are not related in the grid at all with any CPT code, where services are often directly connected in the grid, there are services that are not mentioned at all. Ms. Lawrence asked if she was speaking of the Rate grid. Ms. Kinnekan said yes.

Mr. Liveratti said to discuss that when we hear the Rates section of the hearing.

Ms. Kinnekan also needed to know about LPN's. She noticed that DHCFP has provided for RN's and their Bachelor's degrees, but she doesn't see any mention of LPN's being able to do any sort of practice.

Ms. Lawrence told Ms. Kinnekan that that can be looked at. For the research, DHCFP had LPN's in the policy originally; it was the Board of Nursing that who said the LPN's are under the same licensure regulation side as the RN's, so the Board said DHCFP was being redundant when they said LPN/RN. So DHCFP can look at it as far as clarification with the Licensing Board how to appropriately word the document.

Ms. Wherry said that DHCFP would expect every organization to assure that they're clinicians are practicing under their individual licensure requirement and with so much of an emphasis on treatment planning, there are differences, for example, between what an RN can do and what an LPN can do and that will be left up to the discretion of the providers to understand what they can and cannot do for that individual's licensure.

Valerie Tines-Braggs of SAFY, representing the Nevada Youth Care Provider Wraparound Committee, would like to discuss Appendix A, page 2. A rehab provider isn't listed to provide services until Level 4, when in actuality the services they can provide begin at Level 2. For instance, Level 2,

Outpatient Services, Rehab providers can do basic living skills, but the Appendix A doesn't show that a rehab provider can perform such services.

Ms. Lawrence stated that all they were trying to do on the right side of the grid was give guidance, that they can add qualified Rehab Providers for Level 2 because they can do basic living skills.

Ms. Tines-Braggs asked about Level 3, because those types of skills are also listed there.

Ms. Lawrence agreed to add the qualified Rehab Providers to Level 3 as well.

Ms. Lawrence stated to Mr. Liveratti that to stay consistent, if it's not on the adult side, they will do the same thing to stay consistent.

Ms. Taycher discussed the handout she brought with her and also had handed out in Carson City. The handout is titled, "Public Hearing 11/15/05, Issues Brought Forward by Nevada PEP". She discussed bullets 1 & 2, about the direct service units allowed prior to the UR process. For Family Support Services, it's four (4) units, or 1 hour allowed. Ms. Taycher doesn't believe that is enough time. The Family Support Service is the service that helps the family understand the whole process that they will be going through, and helps them be comfortable with that process. They believe that on the front-end, prior to the service plan being approved and going through the Utilization Review (UR) process, the families need the support at that time, so they are recommending that the direct service units be changed to allow for 20 – 40 units, which would allow for five to ten hours, prior to the UR authorization.

Ms. Lawrence explained how they came to approve the 4 units was because there was a UM committee that was formed between different agencies and providers and this was the number that was agreed upon between them to provide. At this time, Ms. Lawrence would not want to overturn what their decisions were to put into this grid, but it can be opened up for another discussion and another public hearing if needed, but at this time, from DHCFP's point of view, she would like to respect the judgment of that committee.

Ms. Wherry on Appendix A, for example, under Level 1 and Level 2 services, we say there would be 4 family support services, or 4 peer support services, and the perception is-depending on the level of intensity of service need of the recipient-that it is very closely tied to when they would require utilization management or not. If somebody is in a fairly stable situation, but need some ongoing assistance with their recovery, then some of those services don't need to be prior authorized up to that cap. However, if that cap is going to be exceeded, then there has to be utilization management, and that process with the vendor for all of the other medical services is not a lengthy process. It depends on the type of service being provided and Ms. Wherry thinks that is one of the things that should be discussed at the provider training. DHCFP can set the expectations for our vendors to the amount of turnaround time that is expected for the authorization of specific services. If for Family Support, for example, authorization is needed within two days, then DHCFP can work with the vendor to say that they have a 48 hour turnaround time, not including weekends and holidays.

Ms. Taycher stated that the process that was undertaken to determine those UR criteria was very rushed. Nevada PEP was invited to be a member, but meetings were scheduled and posted to be there if you could. The decision ended up being with people who could attend the last-minute scheduled meetings. To characterize that as a stakeholder agreement process, when it was a very rushed process and did not consider the way family support services have been provided on the front end prior to the service plan; she would like reconsideration on that.

Also she understands family support services as designed, can be provided only after it's written into the service plan, so it's not just the UR process and how long that takes to happen. Ms. Taycher has data at her agency that shows how long it takes a family to get a fully authorized service plan and it's quite a lengthy process. She understands we will all work together to streamline that, but prior to that service plan being in place and approved, and the UR process, families are asking for help, and that's where Nevada PEP's service is most valuable.

Ms. Wherry discussed Ms. Taychers handout. Ms. Wherry thinks this is one of the bumps that need to be worked out as time goes on, that's part of the goal of DHCFP for this chapter was to open up the whole market. Depending on the networks Ms. Taycher has, and the networks the families involved have, with regard to who the QMHP may be and the treatment planning process, etc., there may be some shifting in the market over time, so by opening up the market, it's hopeful that some of those processes would become more expedited.

Ms. Taycher discussed the second bullet that asks, "Is there a cap on the number of service units a recipient may receive per month? Per year?" Ms. Taycher would like to know if there is a cap on family support services, and whether there is a cap in the proposal that the group mentioned earlier had come up with.

Ms. Lawrence stated there is no cap, only the service utilization cap as to when an authorization is required. But such as therapy does have some caps, there are no caps on the Peer- and the Family Support Services, it's just based upon UM decision.

Mr. Liveratti added that it's based on whether medical necessity still exists. Medical necessity is your only cap. If it doesn't exist, then there are no more services, but as long as it does exist, services can be provided.

Ms. Taycher would like it for the record that she'd like to consider more than the four units prior to the UR.

Mr. Liveratti asked if there were any questions or comments and there were none in Carson City or Las Vegas.

Mr. Liveratti closed the comments on MSM Chapter 400 and made the recommendation to Ms. Wherry that they accept the chapter as written with the following additions, comments being inserted:

The five pages that Ms. Lawrence and her staff have provided, the comments that Ms. Merrifield is going to send up to DHCFP, for section 402.14, 403.1, 403.3.1,403.6.3 and 3(C), 403.10A.6, also the changes that Ms. Taycher made to 403.6.1, and the corrections that are being made to Appendix A to allow basic skills. Also, to look for the term Service Coordinator Plan and change that reference. There are also several references where it says "DCFS" and will change that to read, "custody of a public agency"; will look for any other glaring grammatical or spelling items and add BLC citations in the section that referenced licensure.

Mr. Liveratti recommends we accept this new chapter.

Ms. Wherry, on behalf of Charles Duarte, Administrator, accepts these recommendations and thanked all the public and private stakeholders for their contribution to the process and also the staff of DHCFP. She directed the staff to work with the word processing staff on effecting the changes.

Mr. Liveratti asked staff to get together with those people who made comments that have not been acted on as of yet and follow up with those and see what other changes can be made.

Ms. Wherry added that once the word processing staff gets all the changes integrated, they will be publishing the final document on the DHCFP website. Sometime in the next month they should be able to see MSM Chapter 400 in its final form on the website.

Mr. Liveratti added that the effective date for MSM Chapter 400 will be January 1, 2006.

2. Discussion and Proposed Adoption of Amendments to the State Plan for Medicaid Services

Mr. Liveratti opened up the Public Hearing for comments on the State Plan Amendment #05-015.

Mr. Liveratti is taking comments only; the panel is not accepting or approving this SPA at this time. The process calls for public hearing for comments, and when DHCFP receives those comments, staff will take them into consideration and formalize the final SPA which will be submitted to the Director's office for approval, which then is submitted to Centers for Medicaid and Medicare Services for approval, and upon their approval, the SPA becomes effective.

John Macnab, MA IV, DHCFP Rates Unit, stated that to facilitate payment of the services described in MSM Chapter 400 earlier, their intent is to amend attachment 4.19-B to the Nevada State Plan for Medicaid and specifically, section 13.d(2).

Section 13.d(2) consists of 2 types of services. One type is Non-Residential Mental Health services and the other type is Treatment Home Providers. Under the Non-Residential Mental Health Services, 13.d(2)a, the reimbursement methodology is for private providers that will provide the following services: Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP), Day Treatment Program, Psychosocial Rehabilitation, Basic Skills Training, Medication Management, Medication Management Training and Support, Crisis Intervention, Case Management, Family-to-Family Support Services, and Peer-to-Peer Support Services. These will be reimbursed based on a statewide fee schedule. The statewide fee schedule is based on prospective pricing models developed specific to each service. For public providers of those same services the intent is to reimburse under Medicare principles of retrospective reimbursement-or cost reimbursement. The Division will develop interim rates from cost studies submitted by sister agencies and then settle those costs.

Under part b) 1), Treatment Home Providers, treatment home services that are provided by private entities will be reimbursed based on a statewide per diem rate. The per diem rate is based on a core of services which reflect the average daily amount of rehab treatment services the treatment home providers are expected to provide in a day.

Part b) 3) states that the same services provided by a public agency will be reimbursed under Medicare principles of retrospective reimbursement. In reviewing the DHCFP draft State Plan before the hearing, a typo was noticed in the last paragraph, under 3), on page 3c, the fourth line up it states, "each state or local government entity is paid the lower of: a) billed charges; or b) and interim rate". It should read, "charges; or b) *an* interim rate". That will be changed before the State Plan is submitted.

Mr. Macnab introduced Karen Harner, from EP&P Consulting, the contractor who developed the assumptions and the rate methodology. He asked her to give a brief overview of the rate methodology for each service to minimize questions.

Ms. Wherry said that she would like to give credit to DCFS as well as the Federal government, because as a state we were rewarded an infrastructure grant to create a more seamless process for the provision of behavioral health services in the state. That grant has funded the contract with EP&P Consulting.

Ms Harner, EP&P Consulting, gave a brief overview of the process, as EP&P has been involved with various state agencies including DCFS and DHCFP. EP&P was engaged to assist the state agencies with this transition and behavioral health redesign, especially with the rate component. They brought to the table previous experience with rates setting, especially related to behavioral health services and other areas, as well as an understanding that each state and program is very different. They have engaged in conversations with state entities as well as with selective providers to understand the process as it stands, understand where they would like to go, so that they could build models that would create rates that were appropriate for the services and to attract providers.

EP& P starts with an hourly wage based on a staffing level they feel is appropriate for the provider qualified to provide the type of service. They use Bureau of Labor statistics information and use the most recent information relevant to the particular staffing level for the service. They inflate that to the midpoint of the rate year, which in this case, would be June of 2006, with an effective date of January 1, 2006. So these wages that you see are market rates from the Bureau of Labor Statistics for Nevada as of June 2006, according to Inflation Factors of Global Insight, a national inflation factor.

On top of the wages they add 27% for employee related expenses which include fringe benefits. Additionally, they offset direct care service hours by accounting for travel time, medical note taking time, and down time (which may include phonecalls) to arrive at the billable hours per day to show that someone who is providing service is not able to bill for every hour they are working, but only the hours they are directly providing services. In that sense they come up with billable hours and that leads them to a direct care adjustment factor which basically just says that considering that they are only able to bill for a certain number of hours per day and not 8 hours per day, they need to increase their hourly wage to account for that factor. There is also an allowance for supervision time by a licensed professional, travel and mileage, if applicable, and administrative overhead, which in most cases is 15%. This builds to a total rate per hour and then is adjusted to meet the unit of measurement for the particular code that has been chosen for the service.

They have worked with the State in various discussions to try to understand the process and the services as they will be provided, keeping in mind fiscal constraints and budget requests that have already been made, and various other factors, to come up with what they think are rates that they would recommend to the State for consideration.

Ms. Wherry clarified that EP&P is using productive and non-productive time in the calculations and she wants to underscore the comment that we do have fiscal constraints; we can't exceed what we have budget authority for from the legislature. Ms. Wherry addressed the audience and asked that if they are here to speak to the fact that the rates are inadequate to please keep those comments brief and realize the important work that they need to do is with DHCFP starting in January 2006 when the Budget Concept papers are developed and when we propose our agency request budget, and then do their own work with the Director for what would be in the Director's budget, work with the Governor for what would be in his budget, and work with the Legislature for what they may approve if it makes it into the Governor's budget. That is the process everyone has to adhere to and every provider needs to advocate for themselves because DHCFP has 10,000 providers it is responsible for assuring access to care for, so the providers need to represent themselves.

Mr. Macnab added that the projected fiscal impact that they came up with may have, over the biennium, a $100,000.00 - $200,000.00 pad, which is slim. The utilization is difficult to project exactly, so that is a big variable, so DHCFP could easily exceed the budget.

Ms. Wherry would like to quote the Administrator, Charles Duarte, he has referred to it in past Legislative testimony that they are "betting on the come", in other words, taking a risk, assuming that they are going to be moving people from higher levels of care that are more expensive, to lower levels of care and hoping that will cost-shift so that we won't exceed our budget, but we are taking an enormous risk, and DHCFP will be the one that takes a tongue-lashing if we exceed the budget.

Mr. Liveratti opened up the hearing for public comment.

Mr. Steve Reagan, a member of Nevada Youth Care Providers, and also a member of the Steering Committee, as well as have operated a treatment home for almost 30 years. As far as providers go, the involvement has never been better. He asked if there a plan to have regular increases.

Mr. Liveratti reminded him that this section was for comment only and if they have other questions to please direct them to Ms. Lawrence.

Mr. Reagan continued that for the past 22 years the providers have received approximately a 26% increase, but wondered if there was a built-in increase over the next 5–10 years or will it remain the same rate?

Ms. Wherry interjected again that this is only a time for comments, but she'll underscore again that DHCFP realizes that there has been a lack of progressive rate increases that have occurred for this provider type. In the past that would have been the provider's work with DCFS and their budget. On a go forward it will be working with DHCFP and its budget and that's where they need to understand our public process. DHCFP will be developing its budgets this next winter. It's very imperative that if

the providers have different trend and forecasting information than what DHCFP is setting out to propose for the next biennial session, that they bring that to DHCFP in January and February of 2006. If the providers do not engage in that piece of the public process then they are left at the hands of the Legislatures during the biennium session and what they choose to fund or not to fund.

Mr. Reagan assumed that there is not a cap on services that might be requested. As to the system that was used in Alabama when they ran out of money, is there a back-up plan on what would be done in that case?

Ms. Wherry explained that the Medicaid program is an entitlement program and one of the reasons she said that if DHCFP exceeds its budget then DHCFP will be taking the tongue-lashing, and one of the reasons DHCFP gets anxious when there's no rainy day fund is because DHCFP can't control all 10,000 providers and all 174,000 recipients. They have a right to access services that are available under the State Plan. DHCFP does have the ability to perform utilization control and that is what utilization management is all about. So much depends on what documentation providers have that they provide to the utilization management company and whether services continue to be authorized. If DHCFP exceeds its budget, then DHCFP will have to go to the Legislature through the Interim Finance Committee and let them know DHCFP is projecting to exceed its budget and then it's their problem, but it's also a DHCFP problem as well. The $100,000 - $200,000 pad is nothing, less than 1/10% of the DHCFP budget. DHCFP will be monitoring closely utilization and sometimes over time, if it is felt we're getting close to exceeding there may be stronger utilization controls put into the program in order to try and contain costs to the best of our ability, but still make sure people have adequate access to care.

Ms. Salmon stated issues that remain unclear to her. In MSM Chapter 400, services are able to be brought to the home, or the residential setting where the child is and in the rates setting it's not clear that there is a rate for home-based individual and family therapy. She sees it referenced as inpatient or outpatient, and residential setting could perhaps be a foster care home, but what about the family's home?

Ms. Wherry responded that her assumption would be that we have a fee schedule available on the DHCFP website that is found in the billing manual. Individual and family therapy services are on that schedule and it would come down to looking in the billing manual and understanding the definition of the code. If the CPT code definition in the CPT code book does not distinguish whether the services are provided in a specific environment, then that is what she needs to use as a plumb line for what they can and cannot bill for.

Ms. Salmon said it was her understanding that as MSM Chapter 400 was being revised that there would be rates built in to support and provide incentives to keep with the service model that they were trying to implement which is bringing services to the child and family, so this is why she says she doesn't see where they have provided any incentives to go to the child and family in the home.

Ms. Salmon brought up section 403.7(1), Basic Skills Training. Four individuals are identified as making up a group whereas in the Group Therapy section, it allows for three individuals. She recommends consistency there.

Ms. Wherry asked Ms. Salmon to send her comments in writing to DHCFP.

Ms. Salmon addressed Appendix A, regarding the previous comment about 4 units and 8 units for Family and Peer Support Services. She thought they were referring to hours and now she sees that it is referring to 15 minute increments and she would like to see if it's possible to have the unit increased because an hour (or four 15 minute increments) isn't sufficient. She states that it's not clear either; as in some of the rates settings it says "telephonic face-to-face team" and under Family-to-Family and Peer-to-Peer it's not clear to if it can only be face-to-face or also by telephone and she would advocate for both.

Mr. Liveratti asked for questions or comments in Carson City and Las Vegas.

Ms. Taycher asked about the Family-to-Family rates. The concern is that Family-to-Family Support services most times are most valuable when the family needs it. It is provided mostly by telephone, they don't wait for a scheduled appointment to talk to a Family Supporter so she'd like some way to be able to pay for the time of the Family Supporters to do the service that the families need.

Regarding support groups, Ms. Taycher requests that there not be a minimum of five Medicaid recipients required in order to bill, as they do family support groups at the neighborhood family service centers and in conjunction with the WIN project and those may or may not be Medicaid recipients that attend the support groups. They have done their calculations over what they could generate from Medicaid billing if one of the Family Supporters was working consistently meeting the 4.5 direct service hour requirement and it will not generate enough funds to cover the cost of having that Family Support Worker and that's outlined on the written testimony. In Nevada there are similar occupations that are currently being paid from $12 - $21 per hour for similar services, yet the Family Supporter rate was billed on $9.06 per hour and that's lower than any State worker makes at this point and not equitable. Outside of Nevada, she has information provided to the panel that Family Support Specialists are making $14 - $16 dollars per hour and this is a Medicaid reimbursed rate. There are national TA providers that can help identify those rates and that Medicaid is paying those rates in other states. Lastly she understands that Medicaid may not be the sole-source of funding for Family Support Services in Nevada, and she looks forward to working with the State and Medicaid to ensure that Family Support Services continues in Nevada and whether or not additional funding sources need to be looked at, she would like to be a part of those conversations.

Mr. Waite discussed the 25 mile limit that is available in the core-services. The providers feel that should be looked at again. Secondly, the State of Nevada has a number of quality providers, some of which are foster care agencies and others that are agencies with national models who happen to own their own buildings and homes as well as include training, evaluation and supervision departments within their models. The providers feel that there should be recognition of those two different types of services that Nevada has.

Mr. Liveratti asked for questions or comments in Carson City and Las Vegas

Ms. Merrifield had a comment regarding the narrative section of the State Plan, she recommends replacing the word wraparound with non-residential rehab services. Wraparound is a case management delivery model, not a service type and she thinks it would be more consistent with the other language.

Ms. Merrifield stated she was only looking at the agenda, not the actual page of the SPA and asked if she could email her comments to the panel as she didn't have the SPA document in front of her and Mr. Liveratti agreed to that.

Ms. Merrifield reiterated the comments by Ms. Salmon regarding the Family-to-Family and Peer-to-Peer. Ms. Merrifield was a member of that committee and the intention was that they didn't discuss what the units looked like, they spoke of hours, so as that part of the hearing has already passed, she would suggest that the units for the Family-to-Family and Peer-to-Peer be changed to hours instead of quarter hour as the intent was to have a minimum of 4 hours, not one hour total. Also, both of those service types include both face-to-face and telephone contact. It has been their experience that the telephone contacts are critical to the service delivery type.

Mr. Liveratti asked for questions or comments from Carson City and Las Vegas.

Ms. Liz O'Brien, NNAMHS, had a comment on page 4 of Section 403 of the MSM Chapter 400, the QMHP "interns" are listed but they have a nurse intern program they're going to begin as well as a psychiatric residency program and she is wondering if those fall under, "Internship clinical practice…"

Mr. Liveratti informed her that section of the hearing was closed.

Mr. Liveratti asked if there were any questions or comments from Carson City or Las Vegas.

Ms. Arguello asked about the EP&P rate study and referred back to the 2002 study. Regarding the possible rate adjustment that is being discussed to possibly take place midyear 2006, if they look back to the 2002 study for the day treatment rates the 2006 rate is within pennies of the recommendation in 2002, so there is no way that can be adjusted for inflation.

Ms. Wherry asked if she was referring to the Rates Taskforce that was one of the strategic plans? Ms. Arguello said yes, that EP&P did for them originally.

Mr. Liveratti asked if there were any questions or comments in Carson City and Las Vegas and there were no more comments.

Mr. Liveratti closed the public hearing on the State Plan Amendment for Behavioral Health Rates.

3. Discussion and Proposed Adoption of Amendments to MSM Chapter 1900-Transportation

Mr. Liveratti opened the hearing for MSM Chapter 1900, Transportation Services.

Bonnie Heidt, SSPS II, DHCFP Managed Care Unit, discussed the changes to MSM Chapter 1900. This chapter was last updated in October of 2002. On October 1, 2003, First Health Services became Medicaid's Fiscal Agent for emergency transportation, when non-emergency transportation services were contracted with the state-wide transportation broker under the State of Nevada 1915-B waiver. These changes have resulted in multiple revisions in provider and recipient responsibility as well as financial responsibility. Revisions to 1900 reflect operational changes that have been in place for 24 months.

The following changes have been made to MSM Chapter 1900:

Escort, Managed Care Organization, Payment Authorization Request (PAR), and Volunteer have been added to the definitions. These can be found in sections 1902.6, 1902.19, 1902.25, and 1902.39. Language has been added to specify that retroactive eligibility does not apply to non-emergency transportation services and that's found in 1903.2(G).

Exceptions have been added to escorts for minor children, and those exceptions can be found in section 1903.2(A) for A., B. and C.

Non-Emergency Transportation (NET) contract language for driver and vehicle safety has been added and those are found in section 1903.2B.7and 1903.2B.8. As a contracted agent of the Director of the Department of Health and Human Services, subject to the requirements of SB401 of 2005, of which number was not assigned when this draft was published but it will be when finalized.

The NET broker may utilize the services of motor carriers that are exempt from certain certification requirements of the Transportation Services Authority (TSA) of the Department of Business and Industry. That is located in 1903.2B.9e.

New language assures that costs of meals and lodging for one attendant will be reimbursed if an attendant is required to ensure that the recipient receives required medical services. This also applies to a parent traveling with a minor child; two parents in the case of a foster or adopted child. This is located in 1903.2A.10.

In emergency vs. Non-Emergency Transportation (NET), "Decision Tree" has been added and a list of accepted transportation procedure codes as well. Upon review before this public hearing, Ms. Heidt noted a few typos that will be corrected before the finalized version.

The pages are numbered wrong, on section 1903 at the bottom it says 1904 and that will be changed all the way through section 1903 to read correctly.

Section 1902.33, Definition of Reasonable Promptness/Timeliness there will be an “s” added to “all request*s”* in the first sentence.

Section 1903.2B, NET Broker Responsibility, Section 8c, “each vehicle shall utilize child *seats*” rather that “sears”.

Section 1905.10 Indian Health Services, the very last sentence has a capitalization that will be corrected.

Mr. Liveratti asked Darrell Faircloth, DAG, if there was a way, as they are referencing SB401in this chapter, if we put this in the chapter and as of January 1, 2006 we now know what the NRS is, can we go back and make that change without having to go to public hearing?

Mr. Faircloth, DAG, answered yes, if he understands correctly what Mr. Liveratti is suggesting, at this point in time the correct citation for that particular bill has been included in the MTL document and that citation for the bill will change when it is codified in the NRS. When that codification is finalized we have a proper citation; and he thinks it would be appropriate, just as a ministerial matter to make the (inaudible) at that time without public hearing.

Mr. Liveratti stated he will advise staff to do that.

Mr. Liveratti asked if there were any questions or comments from Carson City or Las Vegas.

Pam Becker, Washoe County Children’s Mental Health Consortium, questioned that they are going to pay a foster family with two adults to drive with a child, but in a family they’ll only pay for one parent, is that correct?

Ms. Heidt stated that is correct, that is how it will be. (Inaudible conversation between Ms. Wherry and Ms. Heidt).

Ms. Wherry clarified that what the CFR (Code of Federal Regulation) distinguishes when more than one person can accompany based on adoption or foster care, not the state. Ms. Heidt confirmed that was where they found the information.

Ms. Wherry stated that Ms. Heidt is taking the Code of Federal Regulations and clarifying in the chapter that the Federal Government has defined that in a foster care or adoptive situation, two parents can accompany the child, but in a situation *other* that that, it’s only one parent.

Ms. Becker asked if that was one of those things that they can address through workshops to get changed with the whole Behavioral Health Network and children have more access to care with parents.

Ms Wherry said that when Ms. Heidt read the citation, this is strictly in the context of when DHCFP would pay for meals and lodging. Typically what this applies to is when a child is sent out of state for medical problems, if there needs to be an adult accompanying a minor child for an overnight or extended stay. In the past they would be asked to use Ronald McDonald House, or something similar and they were not reimbursed for meals or lodging. In the future, DHCFP will pay for the meals and lodging for one person, but the Federal rules allow that for an adoptive or foster care child there could be two adults, so it’s a very limited situation where we incur the expenses for meals and lodging.

Mr. Tony Greenway with Medic West Ambulance in North Las Vegas asked about the definition of Emergency Medical Transportation section 1902.14. Currently the definition states that an air or ground ambulance resulting from a 911 communication is considered emergency medical transportation. He would like clarification that an immediate response based out of a 911 communication that did not require lights and sirens be considered under the same definition.

Ms. Wherry stated that DHCFP is not qualifying the use of lights and sirens, they aren't differentiating the two.

Mr. Greenway asked about the new definitions of Scheduled Emergencies and Urgent Services, 1902.35 and 1902.38 respectively. When his company bills and these two services are provided, when he looks at page 3 of section 1905, the Transportation Procedure Codes, he's not seeing codes for these two items.

Ms. Heidt stated that was probably an oversight and that the codes can be added.

Mr. Greenway asked about the decision tree for emergency and Non-Emergency Transport.

Ms. Wherry asked if he had a specific recommendation regarding this next question. Is there a code or code set that he feels is lacking the he proposes needs to be added?

Mr. Greenway could draft language in a few minutes and come back after questions/comments are done to propose language. He is more concerned about if the codes were omitted in error, or if his company was misreading the codes.

Ms. Wherry directed him to the Billing Manual, because that manual doesn't have to go through the public hearing process, so if the definitions in 1902.35 and 1902.38 are accurate, but missing the codes, then he can work on these items with Ms. Heidt with regard to the Billing Manual.

Mr. Greenway asked again about the emergency vs. non-emergency Decision Tree, he mentioned that the second major box from the top says, "Provide transportation, submit claim to Medicaid FFS fiscal agent", the question regarding this is what if the patient has Medicaid MCO and not FFS?

Ms. Wherry said that the language needs to be modified to say, "…submit claim to appropriate Managed Care Plan or Fiscal Agent".

Mr. Greenway wanted to alert the panel to "erroneous omissions" within the Decision Tree. It appears that there are some boxes with incomplete sentences. Ms. Heidt stated that they'll fix that as well.

Ms. Wherry clarified that the Decision Making Tree is just a visual guide only to help providers determine whether an item is an emergency or non-emergency situation. The actual Policy or Regulations are in Chapter 1900. The tree is just a visual accompaniment.

Mr. Liveratti asked if there were any questions or comments in Carson City or Las Vegas.

Mary Ruth Johnson, Remsa Ambulance Service in Washoe County had a question regarding a memorandum on page 1, number 1, the background and explanations. Ms. Heidt had mentioned the revisions to MSM Chapter 1900 reflect and have been in place for 24 months, however, there are certain issues reflected later in the chapter that have not been addressed by the NET broker and claims have been denied for items not listed in writing in the previous chapter. She asked if there is going to be an actual date and are they going to be able to reflect those policies for the past 24 months?

Mr. Liveratti stated that this revision on this chapter, the date that this chapter is rewritten, will have today's date (November 15, 2005) if it is approved. What was officially in effect prior to this is what was in writing at that time, which he isn't certain that MSM Chapter 1900 was ever "approved" in that aspect. The last Transportation chapter goes back quite a ways, so he's not aware the chapter was even approved 2 years ago. To look for an "official" MSM Chapter 1900 previous, it would be the one prior to the one done 24 months ago.

Ms. Wherry said that when Ms. Heidt refers to the apparitional changes that have taken place, she is referring to October 2003 when DHCFP engaged in the 1915B Waiver process with the Federal

Government. That Waiver is what we follow for the administration of the program along with whatever policies existed at that point in time that had been approved in the regulatory process.

Ms. Johnson asked about 1902.2, Advanced Life Support (ALS). The definition's last sentence states, "An ALS assessment does not necessarily result in a determination that the recipient requires an ALS level of service." Who interprets this definition, is it going to be down coded to a Basic Life Support (BLS) level when billed to CMS?

Phil Nowak, Chief of Managed Care Unit, DHCFP responded that at the time the billing is submitted is when the determination will be made, as with any billing, whether or not they meet the criteria for ALS or BLS.

Ms. Wherry reiterated that just because they did an assessment, doesn't necessarily mean the recipient qualifies for that level of service. From a fraud and abuse perspective, DHCFP doesn't tell providers how to bill, they need to follow the standard of practice in the community. If the assessment was performed and the recipient did not meet the level of service based on that assessment, and that case was pulled for review through the SURS unit, then the provider may be at risk, for example, for up coding based on their documentation. Providers are responsible for making the determinations as to the proper codes and billing correctly.

Mr. Liveratti added that if the standard of care is changing and DHCFP is falling behind on issues, the providers need to alert DHCFP to that so that we can update our policies appropriately.

Mr. Nowak added that in specific reference to transportation, a good example of where that was the case and required some additional precision in the language, was the boundary between what is Non-Emergency and a *Scheduled Emergency*. What evolved from that is the concept of Specialty Care Transport, which was beyond the transportation in a non-medical way, someone to a covered service vs. someone who is scheduled in advance but would require medical attention, of which without could result in a life-threatening situation. There was no coding for such a situation, so that is what precluded the adjustment in the chapter.

Ms. Wherry let Mr. Novak know about the previous discussion today regarding the Scheduled Emergency Transportation and that DHCFP asked for collaboration between First Health, the providers and DHCFP with regard to the Billing Manual. If there is now an opportunity for clarification, she would appreciate any.

Mr. Liveratti allowed 10 more minutes on this chapter for discussion.

Ms. Johnson brought up section 1902.19, the Managed Care Organizations (MCO's). It states in the chapter that, "an MCO or HMO, by Nevada Medicaid standards, is an entity that must provide its Medicaid or Nevada Check Up enrollees"…."contracted State Plan benefits". With Health Plan of Nevada (HPN) and Nevada Care, for Remsa's emergency services, these MCO's are not following State guidelines and this may go back to the fact, as Mr. Liveratti explained, that there hasn't been an "official" chapter for several years. She asked if the HMO's are going to have to follow this chapter as well, or are they contracted with the State of Nevada and if so, can they clarify?

Mr. Nowak said that the chapter is what defines Medicaid policy, and from that standpoint any contracted entity is bound by that chapter, as well as the HMOs.

Ms. Wherry clarified that DHCFP does have a contract with the Managed Care plans, and unless that contract stipulates a variance from the regulatory language in MSM Chapter 1900, then they are bound to follow the regulatory language in MSM Chapter 1900 once it is approved.

Ms. Johnson referred to the coding issues brought up previously and asked if there was going to be a specialty code for Scheduled Emergencies or an urgent service. Per section 1905.8, the Emergency Transportation Procedure Codes, there are several issues that are incorrect as far as the codes listed.

The codes listed are the proper codes, however, from a billing aspect there wouldn't be any other codes for Scheduled Emergency, you would use the type of codes listed on this page.

Ms. Johnson also pointed out that there are two mileage codes listed: A0380 and A0390, that are outdated and no longer in use per CMS. A0425 is the only code for ground mileage and also the fixed Air Wing Mileage and Rotary Wing Air Mileage. Also, A0426 and A0428 are both for Non-Emergency Transports. There is a section in the chapter concerning pending Medicaid recipient eligibility and they are wondering if these codes would be used in billing the NET broker in the case of a pending Medicaid patient.

Mr. Liveratti explained they can't bill Medicaid for a "pending" recipient. Medicaid only pays if they've been approved for Medicaid. If Remsa provides service to someone pending Medicaid, and they're not approved, they are allowed to bill the patient; however, if the patient is approved later, then they would bill Medicaid for the service.

Ms. Johnson clarified that this is in regards to when the transportation takes place while the patient is pending Medicaid, and once approved, neither the NET broker nor First Health is taking responsibility. Mr. Liveratti said that is a contract issue that DHCFP staff will have to work with the contract, or the fiscal agent, First Health to straighten out, but Remsa will get paid for providing that service as long as they meet the policies.

Ms. Wherry asked Mr. Nowak to make a formal amendment to MSM Chapter 1900 to remove the emergency transportation procedure codes (section 1905.8) and place them in the Billing Manual. She would like for him to make a formal amendment before the chapter is approved.

Mr. Nowak agreed to do so.

Ms. Johnson spoke of section 1904 page 6, under #2, Eligibility. (Due to the incorrect pagination of the chapter, she is actually speaking of Section 1903 page 6). The last paragraph states, "No payment will be made for non-emergency transportation provided while a recipient's Medicaid application was pending. Retroactive eligibility does not apply to non-emergency transportation services".

Ms. Johnson asked if there was going to be an advanced beneficiary notice that has to be given to the recipient when the transportation is scheduled to let them know that they have not been approved for Medicaid and that it is not a covered service, or is this something the transportation provider or hospital is going to have to provide to the recipient?

Mr. Nowak answered that the reason that language was put into the chapter is because, from the provider's standpoint, there is a need to verify eligibility before rendering service. Otherwise when the recipient's status changes, since the services were provided, it makes it complicated. The consistent message to recipients is when you are deemed eligible you are notified, but not before.

Ms. Wherry said that what is probably confusing is that for the rest of the Medicaid policies, if the services provided are provided to a person in a pending status, the payment of that services is not based on the date of determination, but the date of eligibility. The determination of eligibility may have been made on one date, but the actual date of eligibility may go back three months. Medicaid would for all services from that eligibility date forward. That is probably part of the confusion. If transportation is being provided to transport a recipient to a physician's office or a medically necessary service, since the service itself is being paid for, why isn't the transportation? And it's being paid retroactively based on the eligibility decision.

Mr. Liveratti told Ms. Johnson that he needed to stop her comments due to time and asked that she get with Ms. Heidt and Mr. Nowak on any issues she has. If there are items to change in the manual, then Ms. Heidt and Mr. Nowak will come back with the new changes.

Mr. Liveratti asked if Las Vegas had any questions or comments before he closed the chapter.

Ms. Salmon spoke regarding 1903.2 and 1903.2a, the Non-Emergency Transportation services. These sections indicate the NET broker is required to authorize the least expensive alternative conveyance available consistent with recipient's medical condition and needs and what they have found is that often what has been offered is bus tokens. Ms. Salmon asked for consideration be given to the issue of the age and number of children needing to go. For example, in order for a parent to take a child to a medical appointment for care, they often are given a bus token in order to take public transportation with multiple children; some of a very young age and this is extremely difficult for these families. She asked that consideration be given to whether transportation could be a taxi or door-to-door for specific situations, not just considering the least expensive mode of transport, but also taking into consideration of the age and number of children that are part of having to meet a medical appointment.

Mr. Nowak clarified the issue of retroactive eligibility. He would propose to amend section 1903.2A(2), Eligibility, to strike the last line of the section that reads, "Retroactive eligibility does not apply to Non-Emergency Transportation services."

Ms. Wherry added that just because the person is eligible, utilization control still applies, so there is still retrospective utilization management on those services; thus if the vendor decided that the transportation was not medically necessary, then they can still deny that.

Mr. Nowak recommended amending section 1905.8, the Emergency Transportation Procedure Codes by deleting these codes from the chapter because they can be incorporated into the Billing Manual.

Ms. Meghan McCann, Logisticare, asked if the section 1903.2A(2) is to be amended as recommended by Mr. Nowak to read, "Retroactive eligibility does not apply to NET" does that change their contract arrangement.

Mr. Nowak responded that they would have to resolve that, whether it either is-as the policy will state-eligible for reimbursement, whether it's then a matter of adjusting the contract with the transportation broker, or treating it as a separate reimbursable service.

Mr. Charles Perry, Nevada Health Care Association (NHCA), asked Mr. Liveratti if he received some written comments he had faxed up to the panel. In the comments he discussed pending patients who require emergency type of transportation even though it's a non-emergent event, specifically, people who cannot be transported in his facility vans and a wheelchair, but rather they require a stretcher that can only be accommodated by MediCar, MediCoach or mostly, in an ambulance service. They feel that in those instances-and they would like to make it exclusive to those instances-where that is the only way they can be transported, after eligibility is established, then at that time those services would be retroactively paid for, just like therapy, room and board, etc.

Ms. Wherry agreed that just because a service was provided and the recipient was in a pending status, once they are determined retroactively eligible, DHCFP still does retrospective reviews to determine whether or not we will pay for that service. Just because the service occurred, does not mean it meets the Medicaid criteria for reimbursement for that service. Ms. Wherry wants to make sure people aren't walking away from the hearing today with the understanding that just because someone is retroactively eligible, whatever occurred during that period of time they were pending, does not mean it's a covered or reimbursable benefit.

Mr. Perry clarified that this would not mean that it is a non-reimbursable or non-covered service.

Ms. Wherry agreed. DHCFP policy and criteria still would apply. DHCFP just cannot authorize a service when a recipient is in a pending status. This is why there are retrospective authorizations and reviews.

Mr. Liveratti closed the public hearing on MSM Chapter 1900. He recommended to the Deputy Administrator, Ms. Wherry that she accept the two amendments by Mr. Nowak, modify section

1903.2A(2) by striking the last sentence, and delete section 1905.8, the listing of transportation procedure codes.

Ms. Wherry approved the chapter on behalf of the Administrator, Charles Duarte, based on the removal of the Decision Tree, which will need to be brought back to another future public hearing.

4. Discussion and Proposed Adoption of Amendments to MSM Chapter 3500-Personal Care Services Program

Mr. Liveratti opened the hearing for discussion on MSM Chapter 3500.

Ms. Jeri Bennett, SSPS III, Personal Care Services Program, DHCFP, discussed what changes were to be made to MSM Chapter 3500. They were to make some corrections that were inadvertently made for items that were inadvertently, and in error, put on the Functional Assessment Form that are part of the policy for the Personal Care Services, MSM Chapter 3500. There are two changes being made. The first change can be found on page 2 of the form under the section, Bathing. According to this chapter, a shower was given a maximum allowable time of 30 minutes, and this was not intended to be in the form, as it's in the chapter that was adopted on June 29, 2005. They are removing that from the form.

The second change is on page 5, Transfers and Positioning, Section F. There is a typo that gave a maximum allowable of 15 minutes per day and it is being changed to 30 minutes per day. 15 minutes is not adequate when allowing 10 minutes per transfer. These are substantive changes as it is part of the policy that the time is based on.

Mr. Liveratti asked for questions or comments from Carson City and Las Vegas.

Ms. Wherry asked if there is a fiscal impact from the proposed changes to MSM Chapter 3500.

Ms. Bennett doesn't believe so because these were changes that were in the policy but not implemented.

Mr. Liveratti closed the public hearing on MSM Chapter 3500 and recommended to the Deputy Administrator, Ms. Wherry on behalf of the Administrator, Charles Duarte to approve MSM Chapter 3500 as submitted.

Ms. Wherry approved MSM Chapter 3500 on behalf of Charles Duarte, Administrator.

Mr. Liveratti opened up the hearing for public comment on any topic.

Ms. Laura Coger, Consumer Direct, made a comment regarding the 10 minutes per transfer Ms. Bennett referred to, because as a personal care giver, it is extremely short. Depending on the person being transferred, that can take much longer than 10 minutes. 30 minutes for the maximum allowable per day is short as well, unless you're getting a patient out of bed once and putting them back at night, but usually there are many more transfers during the day than that.

Ms. Wherry reminded everyone that Medicaid does cover other benefits other than Personal Care Aid, and safety is always a primary concern. For really difficult transfers, DHCFP also asks people to consider whether there is a medical necessity for DME equipment that would help support the safe and more efficient transfer of patients.

Mr. Liveratti asked for questions or comments from Carson City and Las Vegas.

Pam Becker, Washoe County Children's Mental Health Consortium thinks DHCFP has made some progress for kids and families today. She will recommend to her Consortium that every meeting be opened up with a standing agenda item that says what's happening with Behavioral Health with

regards to Medicaid, what questions/concerns her employees have that they can discuss and be a conduit for that, especially if they are uncomfortable speaking with DHCFP directly.

Ms. Wherry thanked Ms. Becker for her comments. One concern DHCFP had from a fiscal prospective, is since we just went through MSM Chapter 3500, this chapter was just developed in 2001 and at that point, we had no provider service agencies, but only home health agencies that provided CNA services. Since that time there are now over 80 personal provider service agencies in the State network. That's how fast the market responded. DHCFP had confidence the market would respond and hope that will do the same thing for Behavioral Health Care.

Mr. Liveratti closed the public hearing at 12:06 p.m.